IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

April 9, 2008

Nancy Duncan
Visions Home Health
209 Shoup Avenue West
Twin Falls, Idaho 83301

Dear Ms. Duncan:

This is to advise you of the findings of the Medicare survey at Visions Home Health which was concluded on April 4, 2008.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **April 22, 2008**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,

RAE JEAN MCPHILLIPS
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

RJM/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137107	A. BUILDING _____ B. WING _____	04/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISIONS HOME HEALTH	209 SHOUP AVENUE WEST TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your agency. The surveyor conducting the review was: Rae Jean McPhillips, RN, HFS Acronyms used in this report: PCC = Patient Care Coordinator POC = Plan of Care	G 000	RECEIVED APR 16 2008 FACILITY STANDARDS	
G 145	484.14(g) COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the agency failed to ensure 60 day summaries were sent to patients' physicians for 4 of 5 sampled patients requiring 60 day summaries (#'s 5, 7, 8, and 15). The findings include: Patient #5 was admitted for home health services on 8/29/07. The clinical record contained a recertification POC for the certification period 2/25/08 to 4/24/08. The clinical record did not contain a 60 day summary. The PCC confirmed, on 4/2/08 at 10:30 AM, that a 60 day summary was not developed and sent to the patient's physician. Patient #7 was admitted for home health services on 4/27/07. The clinical record contained a	G 145	As each patient is due for recert, the record will be pulled and a checklist attached. Each staff person will initial the checklist as their step in the process is completed. The data entry staff designated each section of the alphabet, will be responsible for the final checklist review to ensure that the 60-Day Summary accompanies the 485 Plan of Treatment (POT) to the physician. Attachment A—Recert Checklist Attachment B—Recert Process Map Attachment C—Care Summary form Attachment D—Staff Meeting Agenda	4/17/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nancy Duncan	Director	4/14/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137107	A. BUILDING _____ B. WING _____	04/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISIONS HOME HEALTH	**209 SHOUP AVENUE WEST TWIN FALLS, ID 83301**

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G 145	Continued From page 1 recertification POC for the certification period 2/24/08 to 4/23/08. The clinical record did not contain a 60 day summary. The PCC confirmed, on 4/2/08 at 10:30 AM, that a 60 day summary was not developed and sent to the patient's physician. Patient #8 was admitted for home health services on 12/18/07. The clinical record contained a recertification POC for the certification period 2/16/08 to 4/15/08. The clinical record did not contain a 60 day summary. The PCC confirmed, on 4/2/08 at 10:30 AM, that a 60 day summary was not developed and sent to the patient's physician. Patient #15 was admitted for home health services on 11/19/07. The clinical record contained a recertification POC for the certification period 1/18/08 to 3/17/08. The clinical record did not contain a 60 day summary. The PCC confirmed, on 4/2/08 at 10:30 AM, that a 60 day summary was not developed and sent to the patient's physician.	G 145	An audit was completed by Patient Care Coordinator from January 1 when we implemented new software and all 60-Day Summaries were written and sent to physicians.	4/10/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137107	A. BUILDING _____ B. WING _____	04/03/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISIONS HOME HEALTH	**209 SHOUP AVENUE WEST TWIN FALLS, ID 83301**

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the State recertification of your agency. The surveyor conducting the review was: Rae Jean McPhillips, RN, HFS	N 000	Refer to response at G 145	
N 186	03.07031.03.CLINICAL REC. N186 03. Clinical and Progress Notes, and Summaries of Care. Clinical and progress notes must be written or dictated on the day service is rendered and incorporated into the clinical record within seven (7) days. Summaries of care reports must be submitted to the attending physician at least every sixty (60) days. This Rule is not met as evidenced by: Refer to Federal deficiency G145, as it relates to summary reports being sent to the physician.	N 186	RECEIVED APR 16 2008 FACILITY STANDARDS	

Bureau of Facility Standards

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE